



**Cheshire YMCA Sea Dog Swim Club Medical Release Form and Authorization to Treat**

Swimmer's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Swimmer's Cell Phone #: \_\_\_\_\_ Parent's Cell Phone #: \_\_\_\_\_

Name of Event: \_\_\_\_\_

**MEDICAL RELEASE**

This medical release form must be signed by a parent or legal guardian and if the swimmer is 18 years of age or older, the swimmer must **also** sign this form.

I CERTIFY THAT, TO THE BEST OF MY KNOWLEDGE AND BELIEF, \_\_\_\_\_ IS IN GOOD PHYSICAL CONDITION AND HAS NO CONDITION THAT WOULD IMPAIR PARTICIPATION IN THIS TRAVEL MEET. AS A PARENT AND/OR GUARDIAN, I HEREWITH AUTHORIZE THE TREATMENT OF MY SON/DAUGHTER BY A QUALIFIED AND LICENSED MEDICAL DOCTOR IN THE EVENT OF A MEDICAL EMERGENCY WHEN IN THE OPINION OF THE ATTENDING PHYSICIAN MAY ENDANGER HIS OR HER LIFE, CAUSE DISFIGUREMENT, PHYSICAL IMPAIRMENT OR UNDUE DISCOMFORT IF DELAYED.

THE ABOVE NAMED SWIMMER HAS OUR PERMISSION AND CONSENT TO TRAVEL WITH THE SEA DOG SWIM CLUB/CHESHIRE YMCA SWIM TEAM AND TO PARTICIPATE IN USA SANCTIONED SWIM MEETS. IN THE EVENT OF ILLNESS OR INJURY TO SAID SWIMMER WHILE TRAVEING TO OR FROM, OR WHILE PARTICIPATING IN, ANY SUCH MEETS, AND AFTER AN ATTEMPT HAS BEEN MADE TO REACH THE PARENTS OR GUARDIAN OF THE CHILD INFORMING THEM OF SUCH ILLNESS OR INJURY, EITHER THE COACHES OR ANY OFFICIAL CHAPERONE, IS HEREBY AUTHORIZED TO CONTRACT FOR AN AUTHORIZED TREATMENT BY A PHYSICIAN OR DENTIST FOR SAID SWIMMER AS FULL AS WE OR EITHER OF US COULD DO IF WE WERE PRESENT. IN CONSIDERATION OF SAID CHILD BEING PERMITTED TO TRAVEL WITH THE SWIM TEAM, THE COACHES AND OFFICIAL CHAPERONES ARE RELEASED FROM ALL AND ANY CLAIMS, LIABILITY, COSTS AND EXPENSES ARISING OUT OF OR RESULTING FROM SAID SWIMMER GOING ON ANY SUCH TRIP, FROM PARTICIPATING IN ANY SUCH MEET, OR FROM PROCUREMENT OF MEDICAL TREATMENT FOR SAID SWIMMER AS AFORESAID.

\_\_\_\_\_  
Parent or Guardian Signature

\_\_\_\_\_  
Participant Signature (if over age of 18)

\_\_\_\_\_  
Home Phone

\_\_\_\_\_  
Work Phone

\_\_\_\_\_  
Cell Phone

\_\_\_\_\_  
Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip

*IF PARENT CANNOT BE REACHED, PLEASE CONTACT:*

\_\_\_\_\_  
NAME

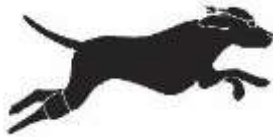
\_\_\_\_\_  
PHONE

\_\_\_\_\_  
RELATIONSHIP TO SWIMMER

\_\_\_\_\_  
ADDRESS

\_\_\_\_\_  
SWIMMER'S PHYSICIAN (NAME AND PRACTICE)

\_\_\_\_\_  
PHYSICIAN PHONE



**INSURANCE INFORMATION:**

INSURANCE COMPANY		GROUP NUMBER	
NAME OF POLICY HOLDER		MEMBER ID #	
POLICY HOLDER'S BIRTHDATE		PLAN NUMBER	
NAME OF EMPLOYER			

**MEDICAL INFORMATION:**

**Allergies:**

Foods: \_\_\_\_\_ Reaction: \_\_\_\_\_

Medications: \_\_\_\_\_ Reaction: \_\_\_\_\_

Environmental: \_\_\_\_\_ Reaction: \_\_\_\_\_

\_\_\_\_\_ My child has allergies that require him/her to routinely receive medication as quickly as possible in order to avoid a medical crisis or for better control of his/her condition. In the interest of his/her personal well-being, I hereby grant my child the authority to carry an Epi-Pen and self-administer it as directed by the prescribing physician when needed. The Epi-Pen was prescribed to my child by a licensed physician for:

\_\_\_\_\_ (please state allergy or condition). My child has the knowledge and skills to safely possess and use the identified medication. I take full responsibility for my child's adherence to the dosing schedule. **I have instructed my child to immediately notify the coaches or chaperones if he/she needs to self-administer, as emergency medical treatment will need to be called for.**

**Release of liability for self-carry and self-administration of Epi-pens:**

In granting this permission for my child to carry and self-administer his/her prescribed epi-pen, I hereby release Sea Dog Swim Club coaches and chaperones from any and all claims and damages which may arise from the administration or lack of administration of such medication.

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date

**PLEASE LIST CURRENT MEDICATIONS (AND DOSAGE) WITH REASON FOR NEED: (Including inhalers and over the counter Medication)**

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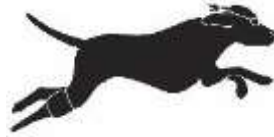


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My child, \_\_\_\_\_, will \_\_\_\_\_ (OR) will not \_\_\_\_\_ be responsible for self-administering above medications.



**RELEASE TO ADMINISTER OVER THE COUNTER MEDICATION**

I give permission for the following over-the-counter medications to be administered to my child if necessary due to injury and/or illness, according to the manufacture's recommendations, by Sea Dog Swim Club coach or chaperone. (Please circle YES or NO):

Tylenol	YES / NO	Benadryl	YES / NO	OTHER _____	YES / NO
Ibuprofen	YES / NO	Sudafed	YES / NO	OTHER _____	YES / NO
TUMS	YES / NO	Pepto-Bismol	YES / NO	OTHER _____	YES / NO

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date

**DATE OF LAST TETANUS BOOSTER:** \_\_\_\_\_

Please let us know if there are any special medical conditions or dietary requirements for your child.

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